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WHY DO MSM GET MORE HIV?

Many explanations have been put forward for the disproportionate burden of HIV in men who have sex with men (MSM) compared with heterosexuals in developed countries. Is it a higher rate of partner change, more dense sexual networks, high transmission probabilities or more concurrent STIs? Goodreau and Golden use a mathematical model to explore the potential impact of sexual role segregation in heterosexuals and the different transmission probabilities of anal and vaginal sex. They suggest that epidemics can occur in MSM at a lower rate of unprotected sex than that needed for heterosexuals.

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RAPID RISE IN HIV-1 DURING CIVIL WAR

It is well known that wars create social disruption and have a major impact on health, including STI. Månsson *et al* studied the prevalence of HIV-1 and HIV-2 in pregnant women in Guinea-Bissau between 1987 and 2004, a period that included the civil war of 1998–9. They observed an increase in HIV-1 and a decrease in HIV-2 over the whole period, but the biggest change was in HIV-1, from 2.5% in 1997, before the war, to 5.2% after (1999). Rates then stabilised. The authors hypothesise that the war might have caused this rapid increase, but that there was no long term effect on HIV-1.

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WHICH SCHEDULE FOR HEPATITIS B VACCINE?

Van Herck and colleagues review the evidence for using different vaccination schedules in people at risk of hepatitis B through sex or injection drug use. Super-accelerated schedules can provide effective early protection but the three early doses within 3–8 weeks need to be backed up by a fourth dose at 12 months for sustained protection. For hard to reach at-risk groups, offering the first part of the super-accelerated schedule might therefore not be useful in the long term. Challenges clearly remain in trying to balance increased initial uptake with long term protection. Which raises the question—would universal infant vaccination be better?

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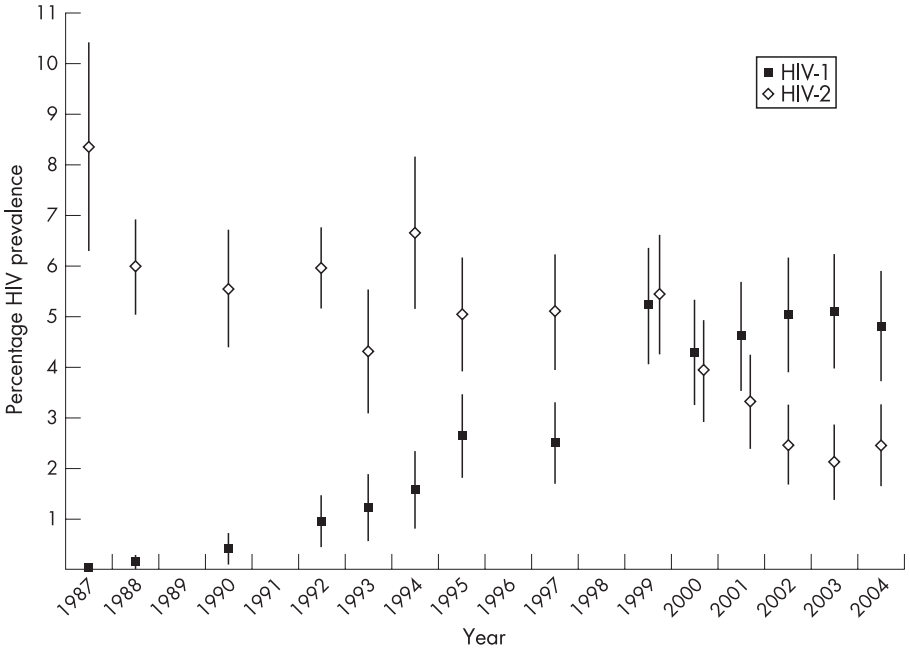

HIV-1 and HIV-2 total prevalence (with 95% confidence intervals) of pregnant women in Guinea-Bissau, (see page 463).

GONORRHOEA HOT SPOTS IN LONDON

Certain gonorrhoea strains in London cluster geographically, particularly in heterosexuals and in areas with a high proportion of residents from black minority ethnic groups. Although the incidence of gonorrhoea amongst MSM could be 20 times higher than among heterosexuals, there is less geographic clustering. People infected with these endemic strains presented at multiple clinics across the capital. These findings come from a study by Risley and colleagues, who combined microbiological, demographic and geographic information about 65% of gonorrhoea strains diagnosed in London genitourinary medicine (GUM) clinics in a 6 month period during 2004. The practical issue emerging from the study is that partner notification efforts have to extend between clinics if they are to have any chance of interrupting chains of transmission.

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CONGENITAL SYPHILIS IN CHINA

Over the past two decades China has experienced a large syphilis epidemic. Sadly, but predictably, this has led to congenital syphilis, with rates increasing from 0.01 to 19.7 cases per 100 000 live births between 1991 and 2005. A case-control study of pregnant women in Shenzhen City, South China, showed syphilis to be associated with unmarried status, less education, multiple sex partners, travel of sex partner in the past 12 months, a history of induced abortion and previous STIs, but not with basic demographic features such as time in the city, district of residence, monthly income or age at first sex. A comprehensive screening programme for pregnant women must be accompanied by basic preventive interventions for syphilis in the population.

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